Continuous Glucose Monitor (CGM)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992

Dexcom G6	Freestyle Libre 2	Freestyle Libre 14 days	Guardian Connect
2 years of age and older	4 years of age and older	18 years of age and older	14 to 75 years of age

Criteria for Approval (All of the following criteria must be met):

- ❑ Diagnosis of diabetes mellitus ❑ Type 1 ❑ Type 2 ❑ Gestational ❑ Other
- ❑ Patient and/or care giver adheres to a comprehensive diabetes treatment plan supervised by the treating provider, and is capable of recognizing and responding to the alarms and alerts of the device.
- ❑ Provider attests to the patient and/or care giver having appropriate ongoing counseling and training for CGM use.

Additional Criteria for Type 2 or Gestational Diabetes or Other Diabetes:

- ❑ Patient requires: *(please select)*
  ☐ Three or more daily insulin injections ☐ Two or more Mixed basal/prandial injections ☐ Humulin R U-500 ☐ Insulin pump **AND**
- ❑ Patient is performing blood glucose testing via fingerstick four or more times per day.
- ❑ Patient's insulin treatment regimen requires frequent adjustment on the basis of their BGM or CGM testing results. **OR**
- ❑ Patient has one of the following hypoglycemia conditions: (please select)
  - ☐ Patient has hypoglycemia unawareness defined as the onset of neuroglycopenia before the appearance of autonomic warning symptoms or as the failure to sense a significant fall in blood glucose below normal levels.
  - ☐ Patient experiences recurrent episodes of severe hypoglycemia defined as a glucose level of less than 50 mg/dl, which are not attributable to some type of dosing error. **OR**
- ❑ Other reason for CGM with clinical rationale: _____

Replacement Receiver (May be authorized when documentation confirms):

- ❑ Current device is deemed inoperable or ineffective due to damage from events outside patient's control.
- ❑ Patient is compliant with device and the device is required and continues to provide benefit to the patient's diabetic regimen.
- ❑ Replacement cannot be obtained through the supplier or manufacturer (warranty has expired).
- ❑ The replacement device is similar to the current device, without additional features or enhancements.

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred CGM, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product. Details: _____ Chart Note Page #: _____

Re-authorization Criteria (all of the following criteria must be met):

- ❑ Updated documentation from the treating provider indicating the device is required and continues to provide benefit to the patient's diabetic regimen.
- ❑ Documentation of a face-to-face visit with the provider in the last 6 months.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date